ABSTRACT
LABOR AND DELIVERY

POLICY
Prior to fetal viability, intentionally undertaking delivery of a fetus is the equivalent of abortion and is not permissible.

After fetal viability has been reached, intentionally undertaking delivery of a fetus is permissible only for a proportionately serious reason.

COMMENTARY
Viability
Viability is the point at which the fetus is capable of surviving outside the womb. There is some elasticity to the concept of viability since the time at which a fetus becomes viable is dependent on the state of technology as well as individual differences in maturation. In the United States, 24 weeks is the current standard for viability.

Undertaking Delivery for Medical Reasons
Undertaking delivery of a preterm fetus (prior to 37 completed weeks of gestation) poses certain risks for the child, ranging from continued survival to the existence of physical and intellectual disabilities to developmental delays. Even when a fetus has reached term status (37-42 weeks of gestation), there are increased complications associated with inducing labor. In order to justify intentionally undertaking delivery after fetal viability has been reached, there must be a “proportionately serious reason” which outweighs these possible negative outcomes. A proportionately serious reason may have to do with the physical welfare of the child, the mother, or both of them. In some cases, an infant’s needs may be better met in a neonatal intensive care unit than by remaining in the womb. It is important to keep in mind that maternal disease can have negative consequences for the fetus as well.

Undertaking Delivery for Non-Medical Reasons
Some women and healthcare providers have opted for elective induction, that is, inducing labor for reasons of convenience (rather than for medical reasons) in the case of a fetus who has reached term status. In general, convenience is not a “proportionately serious reason” for intentionally undertaking delivery because of the complications associated with inducing labor in comparison with spontaneous labor.

Undertaking Delivery in the Case of Fetal Abnormalities
When a fetus has been diagnosed with a serious abnormality incompatible with extended postnatal life, some wish to terminate the pregnancy by abortion or by undertaking delivery of the fetus immediately. For discussion of such cases, see the entry Anencephaly.

POLICY
LABOR AND DELIVERY

Explanation of Terms and Procedures
An infant may be born preterm, term, or postterm. (1) A term infant is one born anytime after 37 completed weeks of gestation and up until 42 completed weeks of gestation (260 to 294 days). A preterm (premature) infant is one born before 37 completed weeks of gestation (259th day). A postterm infant is one born anytime after completion of the 42nd week of gestation beginning with day 295. (2)

Fetal viability is ‘the point at which the fetus is capable of surviving outside the womb.” (3) In the United States, it is commonly placed at 24 weeks of gestation. (4) A preterm infant can be either non-viable or viable.
For present purposes, intentionally undertaking delivery of a fetus refers to intentional action to effect the delivery of a fetus, whether taking the form of inducing labor or cesarean section. It contrasts with the natural, spontaneous occurrence of labor.

**Policy**

Prior to fetal viability, intentionally undertaking delivery of a fetus is the equivalent of abortion and is not permissible

After fetal viability has been reached, intentionally undertaking delivery of a fetus is permissible only for a proportionately serious reason.

**Sources of Policy**

These policy statements are based on the Ethical and Religious Directives for Catholic Health Care Services from the United States Conference of Catholic Bishops (5):

Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion... (No. 45)

For a proportionate reason, labor may be induced after the fetus is viable. (No. 49)

**Notes**


2. Ibid., pp. 5, 690.


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**COMMENTARY**

**LABOR AND DELIVERY**

**Viability**

According to the Ethical and Religious Directives for Catholic Health Care Services, the point at which the fetus is viable, that is, capable of surviving outside the womb (1), is a critical consideration in determining the moral permissibility of undertaking delivery of a preterm fetus. (See Policy and Sources of Policy). In the United States, twenty-four weeks is considered the current standard for viability (2), although infants of lesser gestation have survived. (3)

It should be recognized that there is some elasticity to the concept of viability. (4) First of all, the time at which a fetus becomes viable is “a function of biomedical and technological conditions.” (5) For example, at the time of the Roe v. Wade abortion decision, viability was placed at 28 weeks but, by the 1980s, advances in neonatal care made 24 weeks the generally accepted dividing line. (6) Theoretically, the perfection of artificial incubation could make the fetus viable at any time. (7) Moreover, “mere length of life is not an exact measure” of viability. (8) The viability of the fetus in fact “depends on the extent of its anatomical and functional development.” (9) Diagnostic procedures for fetal maturity, such as amniocentesis, may assist in determining the point of fetal viability. (10)

**Undertaking Delivery for Medical Reasons**

According to *Williams Obstetrics*, a standard reference text in the field, delivery of a preterm fetus is indicated, even in the absence of spontaneous labor, in cases of compromised maternal and/or fetal health (11):

All too often, pregnancy complications oblige a clinical decision to effect preterm delivery rather than continue pregnancy in a deteriorating uterine environment for the fetus. A host of pregnancy disorders may mandate such a choice. Most commonly, these complications of pregnancy threaten fetal health so that a continued uterine existence will likely result in fetal death. Many examples may be
The moral question about intentionally undertaking delivery of a preterm fetus arises from the fact that preterm delivery poses certain risks for the child. (13) In some cases, the infant’s survival may be in question. (14) But even apart from the question of survival, there is the issue of “the quality of life achieved by quite immature, extremely-low-birthweight infants.” (15) Specifically, “appreciable compromise, both physical and intellectual, afflicts many such children.” (16) In fact, being born just two to four weeks preterm can put a child at risk for some developmental delays. (17)

A preterm fetus is one born before 37 completed weeks of gestation, while viability is commonly placed at 24 weeks of gestation (see Explanation of Terms and Procedures). Thus a preterm fetus could be non-viable or viable. According to Catholic moral teaching, it is not permissible to intentionally undertake delivery of a preterm fetus prior to viability, even for medical reasons (see Policy). Rather, the morally appropriate course of action is to attempt to manage the medical problem with continuation of the pregnancy, at least until viability is reached.

Even when the fetus has reached the point of viability, there must be a proportionate reason for intentionally undertaking preterm delivery. This is in accord with the ethical principle of double effect. (18) In other words, the risks associated with preterm delivery must be counterbalanced by considerations of equal or greater importance in favor of delivery of a viable fetus. Even when a fetus has reached term status of 37 to 42 weeks of gestation, there must still be a proportionate reason for intentionally undertaking delivery in the absence of natural, spontaneous labor because of increased complications associated with inducing labor (see below).

Proportionate reasons to intentionally undertake delivery of a viable fetus may have to do with the welfare of the child, the welfare of the mother, or the welfare of both of them. For example, it can happen that a fetus is not receiving an adequate placental blood supply. (19) In this case, the infant’s needs may be better met in a neonatal intensive care unit than in the mother’s womb. Or again, multifetal pregnancies may result in growth retardation if the fetuses remain in utero. (20) Other conditions which may outweigh the value of carrying a fetus to term include major maternal systemic disease, such as hypertension or diabetes. (21) As noted in Williams Obstetrics, such maternal disease can have negative consequences for the fetus as well: “All too often, pregnancy complications oblige a clinical decision to effect preterm delivery rather than continue pregnancy in a deteriorating uterine environment for the fetus. Most commonly, these complications of pregnancy threaten fetal health so that a continued uterine existence will likely result in fetal death.” (22) Or again, postterm pregnancies carry an increased risk of fetal mortality. (23)

**Undertaking Delivery for Non-Medical Reasons**

Some women and healthcare providers have opted for elective induction, that is, inducing labor for reasons of convenience rather than for medical reasons. For example, a pregnant woman who is near her due date may have labor induced “just to get the birth over with.” (24) However, Williams Obstetrics notes that inducing labor “is associated with increased complications as compared with spontaneous labor”(25), including an increased incidence of chorioamnionitis (inflammation of the fetal membranes due to intrauterine infection) and cesarean delivery (26) One study, conducted in Belgium, compared over 15,000 births occurring during winter conditions (1996-97) in first-time mothers who had healthy, uncomplicated pregnancies. Half of the women had labor induced artificially shortly before their due dates while the other half went into labor naturally. (27) The study found that “women with induced labors used significantly more pain medication and had more cesarean births due to both fetal distress and stalled labors.” (28) Further, “that group also had more forceps and vacuum births and had more babies admitted to intensive care.” (29) The existence of such complications indicates that convenience of delivery time does not in itself constitute a “proportionate reason” justifying artificial induction of labor. Indeed, Williams Obstetrics states that “the concept of elective induction for either convenience of the practitioner and/or the patient is not recommended by us, or by the American College of Obstetricians and Gynecologists.” (30)

At the same time, Williams Obstetrics notes some special situations which “present valid indications for induction at term.” (31) One example given is the case of “women at term with a history of rapid labor and/or who reside an appreciable distance from the obstetrical facility,” situations which may be “aggravated by geographical (mountainous) and/or climatological (winter conditions) circumstances.” (32)

**Undertaking Delivery in the Case of Fetal Abnormalities**

When a fetus has been diagnosed with a serious abnormality incompatible with extended postnatal life, such as anencephaly, some wish to terminate the pregnancy by abortion or by undertaking delivery of the fetus immediately. For an extended discussion of the ethical issues involved with intentionally undertaking delivery in these cases, see the entry *Anencephaly.*
Notes


8. Ibid.

9. Ibid.


12. Ibid. *Abruptio placenta*, placental abruption, is the separation of the placenta from its site of implantation before the delivery of the fetus; ibid., p. 621.


15. Ibid.

16. Ibid.


18. Thomas J. O’Donnell, *Medicine and Christian Morality*, 2nd ed. (New York: Alba House, 1991) p. 184. The principle of double effect, “which is designed to provide moral guidance to an action that could have at least one bad and one good effect, holds that such an action is permissible if it satisfies these four conditions: (1) The act itself must be morally good or neutral (for example, administering a pain-killer); (2) only the good consequences of the action must be intended (relief of the patient’s suffering); (3) the good effect must not be produced by means of the evil effect (the relief of suffering must not be produced by the patient’s death); (4) there must be some weighty reason for permitting the evil (the relief of great suffering, which can only be achieved through a high risk of death).” President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* (1983; reprint New York: Concern for Dying), p. 80, n. 110.


22. Ibid., p. 281.

23. Ibid., pp. 731-2.


26. Ibid., pp. 470, 814.

28. Ibid.

29. Ibid.


31. Ibid.

32. Ibid.